"HEALTH STATUS OF TRIBAL WOMEN: A SOCIOLOGICAL STUDY ON YERAVA TRIBE IN KODAGU DISTRICT"

SYNOPSIS

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INTRODUCTION

India is inhabited by indigenous people who form the second-largest population in the world. Their living habitat and the natural resources they rely are intricately related to their identities, cultures, livelihoods, and physical and spiritual well-being. Indigenous people exist in groups and communities that are culturally unique from one another. The indigenous communities in India are called "Adivasis", believed to be the original inhabitants of India. Different groups occupy different parts of India, having their cultural characteristics and levels of development. They were referred to as "aboriginals, adivasis, hill tribes, primitives, backward Hindus, etc., still dependent on hunting, agriculture, and fishing. Majority of the tribal population is concentrated in the eastern, central and western belt covering nine states: Odisha, Madhya Pradesh, Chhattisgarh, Jharkhand, Maharashtra, Gujarat, Rajasthan, Andhra Pradesh and West Bengal. The population of the Northeastern region is 12 percent; the Southern part is 5 percent and 3 percent in the Northern States. Some tribal groups are untouched by the changes of the modern world. However, some tribal communities are at varying levels of social, economic, and educational development because they live in various ecological and geo-climatic settings ranging from plains, forests, hills and inaccessible locations.

According to the Census of India 2011 and Ministry of Tribal Affairs, India is inhabited by 10.45 crores of Scheduled Tribe (ST) Population; they represent 8.6 per cent of the country's total population, 89.97 percent live in rural areas and 10.03 percent in urban areas and are considered as the autochthonous people of the land. 705 distinct ethnic groups have been designated as Scheduled Tribes, and they are dispersed throughout 30 states and union territories. The ST male and female populations are 5.25 crores and 5.20 crores, respectively. Most of the tribal community live in rural and isolated locations and is one of

society's most vulnerable groups. Moreover, they lag behind all other social groups in social, health and developmental indicators (Office of Registrar General & Census Commissioner India and Ministry of tribal Affairs). India's socio-economic transition will only be complete by addressing the needs of the most vulnerable population. Therefore, it won't be feasible to accomplish the UN Sustainable Development Goals, to which India has committed itself together with other nations (Nitti Ayoga). On one end of the spectrum, some tribes have assimilated and adopted a modern way of life, but on the other, the Government of India has identified 75 Particularly Vulnerable Tribal Groups (PVTGs) in 15 states and union territories. These tribes are still agricultural and have very low literacy rates; they are still far from the influences of modern civilisation. As a result, their population is stagnant and even declining and the Government has introduced special socio-economic development programmes.

The term Scheduled Tribe first appeared in the Constitution of India. Article 366(25) defined Scheduled Tribes as "such tribes or tribal communities or parts of, or groups within such tribes or tribal communities as are deemed under Article 342 to be Scheduled Tribes for this Constitution". A tribe is a "collection of families bearing a common name, members of which occupy the same territory, speak the same language and observe certain taboos regarding marriage, profession or occupation and have developed as well as assessed system of reciprocity and mutuality of obligations"(Majumdar, 1958 p.355). In India, the tribal population is numerically small, represents an enormous diversity of groups, vary among themselves to race, language and linguistic traits. physical features, population size, the level of acculturation, dominant modes of making a subsistence, level of development and social stratification (Ministry of Tribal Affairs 2014).

The tribal population is among the most marginalised and vulnerable communities. The majority of the tribes reside in rural areas, in remote forest areas with little or no essential

municipal services such as transportation, roads, primary health care centres, safe drinking water or sanitation etc. Therefore these communities lag behind the general population with respect to income, education, health and nutrition. Many studies have revealed that the tribals are facing lack of basic amenities like personal hygiene, poor sanitation, poor health service, problems with food supplies, water contamination, and insufficient food intake speculate on the health status of tribals.

Basu (1990) stated that in India, tribals are neglected and discriminated against in terms of income distribution and social status; most of them are poor, backward, uneducated and lead a tough and miserable life,

Growth of Tribal population in India (1961-2011)

The number of scheduled tribes was 8.6 percent of the country's overall percentage. The Indian constitution emphasises the importance of making specific efforts to ameliorate the situation of economically and socially deprived parts of society including scheduled tribes.

Table 1.1: Growth of Tribal Population in India 1961 – 2011

Census Year	Total Population (Millions)	Scheduled Tribes Population (Millions)	Percentage of Scheduled Tribes Population	Decadal Rate Growth
1961	439.24	29.88	6.86	41.19
1971	548.16	38.02	6.94	33.84
1981	683.33	51.63	7.83	24.80
1991	846.42	67.76	8.08	24.69
2001	1028.74	84.30	8.20	22.70
2011	1210.19	104.30	8.61	23.70

Source: Census of India Reports, 1961-2011, Government of India.

Table 1.1 shows the growth of the Scheduled Tribes population in India. The population of Scheduled Tribes has increased from 29.88 million in 1961 to 104.30 million in

2011. The decadal growth rate shows that the population of Scheduled Tribes has declined from 41.19 percent in 1961 to 22.70 percent in 2001. However, it increased by 1% in 2011.

Scheduled Tribes in Karnataka

Karnataka is situated in the Western region of India. Its population was 61.13 million as per 2011 Census of India; 61.43% live in rural areas. Agriculture is the primary occupation for most in rural Karnataka. Karnataka has 42,48,987 tribal people, which is 6.95 percent of the total population. There are 50 different tribes living in Karnataka, notified by the Government of India, of which 14 tribes, including two primitive tribes, are primarily the natives of the State (Census Report, 2011).

Percentage of Tribal Population in Karnataka

Table 1.2: Percentage of tribal Population in Karnataka

Sl. No	Districts	Percentage of Tribal Population
1	Raichur	19.03
2	Bellary	18.41
3	Chitradurga	18.23
4	Bidar	13.85
5	Chikkabalapura	12.47
6	Davangaere	11.98
7	Koppal	11.82
8	Yadagiri	12.51
9	Chamrajnagar	11.78
10	Mysore	11.15
11	Bangalore	1.98
12	Hassan	1.82
13	Mandya	1.24

Source: Census 2011

Raichur has the highest tribal population (19.03%) of Scheduled Tribes. The ST population primarily lives in rural areas (84.76%). Studies on Tribes of Karnataka are found in several published works such as Thurstons' “Ethnographic Notes on Southern India" (1906) and “Caste and Tribes of Southern India” (1909, Vol I A & B) by Thurston; “Mysore

Caste and Tribes" (1928, 1930, 1931, 1935 4 volumes) by Ananthakrishna Iyer', and "The Coorg Tribes and Castes" (1948) by L. A. Krishna Iyer.

Tribal Concept of Health

Health is considered a precondition for human development and well-being. Health, education, and ability to generate income are the three factors taken into account by the UNDP Human Development Index (HDI). "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," is health according to the World Health Organization (WHO). The World Health Organization has noted that the physical environment, including safe water and clean air, healthy workplaces, safe homes, communities as well as roads, all contribute to good health. Employment and work conditions are also factors in health status, with higher income and social status linked to better health; lower education levels linked to poor health, more stress, and lower self-confidence. The influence of genetics and inheritance on longevity, health, personal behaviour and coping mechanisms, balanced eating, regular exercise, quitting smoking, drinking alcohol, and how we handle life's stresses and challenges all have an impact on health. Most important, however, are health services, high quality, accessible health services, and health promotion that contribute to public health (WHO, 1992).

Women constitute 50 percent of the population and are responsible for maintaining their health and taking upon the responsibility of other family members by ensuring that home and the neighborhood are clean and tidy. However, helping others to lead a healthy life may lead them to neglect their health, which may affect the overall quality of life (Maiti, 2013).

Health is now largely acknowledged as a fundamental human right and as a right that cannot be subjected to any kind of discrimination. All women have a right to the highest possible degree of physical and mental well-being. Every woman has the right to seek to the

fullest extent all parameters of emotional, social and physical good health; these are asserted by social, political and economic conditions of the prevailing period, and the biology of women. But the irony is that women themselves are many times denied their basic rights. Compared to the general population the health status of tribal women is very low. Among all the tribes, women work hard, and toil in all-weather which leads to insidious attacks of disease. Due to varied and distinct features of the mode of living, tribes are easily prone to different health issues. The tribes are the victims of communicable and non-communicable diseases such as reproductive health problems, malaria, tuberculosis, hepatitis, sexually transmitted diseases, diarrhoea, scabies, cough and HIV/AIDS, etc. are prevalent among the tribes (Balgir 2006). The health issues are dealt by the medical staff at the primary health centres or by traditional indigenous health practitioners. Health problems and health practices of tribal communities have been profoundly influenced by the interplay of complex social, cultural, educational, economic and political practices. The common beliefs, customs, traditions, values and practices connected with health and disease have been closely associated with the treatment of diseases (Balgir 2011). Tribal groups are the poorest, most marginalised and most vulnerable communities in India experiencing extreme levels of health deprivation (Willis et al 2004, Basu 1992, 1994, Chhotry 2003).

The indigenous tribes are more vulnerable to illness, and they lack the necessary access to basic medical services. They are exploited, neglected, and vulnerable to diseases that cause significant malnutrition, morbidity, and death (Balgir 2004). Poverty, illiteracy, ignorance about the causes of diseases, a hostile environment, no proper sanitation, lack of access to good drinking water, and blind beliefs all contribute to their misery. The main causes of high maternal mortality rate are poor nutritional status, anaemia, unhygienic and primitive practices for parturition. The average calorie and consumption of protein were very low among pregnant as well as lactating women. Some of the preventable diseases like

tuberculosis, malaria, gastroenteritis, measles, whooping cough, skin diseases etc., are high among the tribals. Due to their isolation, remoteness, and lack of access to developmental processes, tribal populations' health is extremely bad and among the poorest of any prehistoric groups (ICMR 2003).

Health and nutrition are complementary to each other. Without taking proper nutritious food health status can neither be attained nor retained. Nutritional status and general health condition indicate the socio-economic conditions that are prevalent in society. Tribal women are malnourished and their dietary energy intake is not adequate to compensate for their heavy physical workload. Tribal women with poor health and nutrition are likely to give birth to low-weight infants. Research and several studies on maternal health reported poor nutritional status, higher levels of morbidity and mortality, low utilisation of antenatal and postnatal care, higher incidence of anaemia, alcoholism, and lack of health-seeking behaviour, household work and lack of accessibility to emergency health care among tribal women when compared to other social groups. Apart from malnutrition and anaemia the health problems prevalent in tribal areas include endemic infectious diseases like malaria, tuberculosis and diarrhoea diseases.

The status of tribal development concerning the health care of tribal women remains poor. Every society has its own sets of beliefs, customs, traditions, knowledge and practices related to health and illness. The tribes have their system of health care which is based on their own belief. Most of the tribes have a strong system of traditional medicine and believe in supernatural power and magico-religious system of health care. Tribes live in harmony with nature and their surroundings (Negi et al. 2002). They believe that benevolent and malevolent spirits control their daily life and these beliefs affect their health practices (Balgir 2011).

Early marriage and childbirth are major determinants of women's health. Inadequate and improper utilisation of health facilities and widespread anaemia among all reproductive age women, lead to high maternal mortality (NFHS-2). A woman's poor health affects not just her but also her family.

Women's health status affects their proportion in the population, working hours, income and their overall contribution in the workplace and in society. Nutrition is an essential component of women's overall health status. The food intake in a woman's lifetime comprises her energy output and workload, her control over resources for household food security and her roles in the food chain.

Factors affecting Tribal women's health

In India, poor health status is due to several linter-linked factors

A. Fertility
B. Education
C. Work
D. Health Problems

Health Care System in India

The health care system is intended to deliver health care services. It constitutes the management sector and involves organisational matters. It operates in the context of socio-economic and political framework of the area. India has a mixed healthcare system, including private and public healthcare service providers. The private health care providers are concentrated in urban areas and the public health care providers in rural areas are based on the population and norms. In India, the private sector shares 70 percent and the public sector shares 30 percent of the cost of health care services. Realising the importance of delivering health services for the rural population the centre, state and several government-related agencies developed a three-tier system that is the Primary Health Centre which is a referral unit for six sub-centres. All Primary Health Centres (PHCs) provide an outpatient service,

which has 4-6 in-patient beds, a medical officer and 14 para-medical staff. The activities of PHC involve curative, preventive, promotive and family welfare services. The Sub-centre is the most peripheral health institution for the rural population. The Community Health Centre (CHC) is the first referral unit for 4 PHCs with specialised care and according to the norms each CHC should have at least 30 beds in hospitals. According to population standards, plain regions need a subcenter, PHC, and CHC for every 5,000, 30,000, and 1,20,000 residents, respectively. The appropriate figures for tribal territories are 3,000, 20,000, and 80,000. There are not enough primary health centres (PHCs), Community Health Centres(CHCs), and sub-centres in tribal communities. And the ones that are already there, lack manpower and infrastructure.

Universal health coverage is attainable when the population obtains services linked to health without going through the financial burden of expensive out-of-pocket payments. It includes good health services, prevention of diseases, treatment and rehabilitation that covers all forms of financial risk protection. Healthcare coverage should be for everyone. Many developing countries still lag in infrastructure for universal health care. In developing countries, healthcare is viewed in terms of two dimensions, the physical accessibility and affordability of healthcare facilities. World Bank 2013 Health Report has mentioned four indicators of healthcare access i.e. accessibility, availability, affordability and quality. These indicators should be interconnected for good health care. Since some rural communities lack infrastructure, roads, and transportation, as well as PHC provision, access to health care is crucial.

Government Schemes for Health Care

1. National Rural Health Mission (NRHM, 2005)
2. Pradhan Mantri Matritva Vandana Yojana
3. Pradhan Mantri Surakshit Matritva Abhiyan

4. Janani Suraksha Yojana

5. Janani Shishu Suraksha Karyakaram (JSSK) (2011)

6. Ayushman Bharat Yojna

A Profile of Study Area

The population for the present study is selected from Kodagu district. Kodagu which is also known as Coorg, is a small district on the slopes of the Western Ghats, which lies on the south-western border of Karnataka State between northern latitudes 11^0 56^0 and 12^0 52^0 and eastern longitude 75^0 22^0 and 76^0 12^0. It was renowned for its coffee plantations and forest wealth, which is endowed with densely wooded hills and fertile valleys. Districts like Hassan in the North, Mysore in the east, Dakshina Kannada in the West and Kerala state to the South surround the district. It has an area of 4102 sq. km and 30 per cent of the district is covered with forest area. Kodagu is the only district to have evergreen forests, semi-green forests, dry and deciduous forests all in one small district. Today, its economy is mainly dependent on Coffee and Tourism. The major rivers originating in Kodagu are Cauvery and Lakshman theertha which are fed by a host of smaller rivers. There are three taluks in the district: Madikeri, Virajpet, and Somwarpet. The district headquarters of Kodagu is a town called Madikeri. The Present study is conducted in the taluks of Virajpet and Somwarpet in Kodagu District. Marked taluks in the map were the areas under study.

Figure 1.1: Map of Kodagu

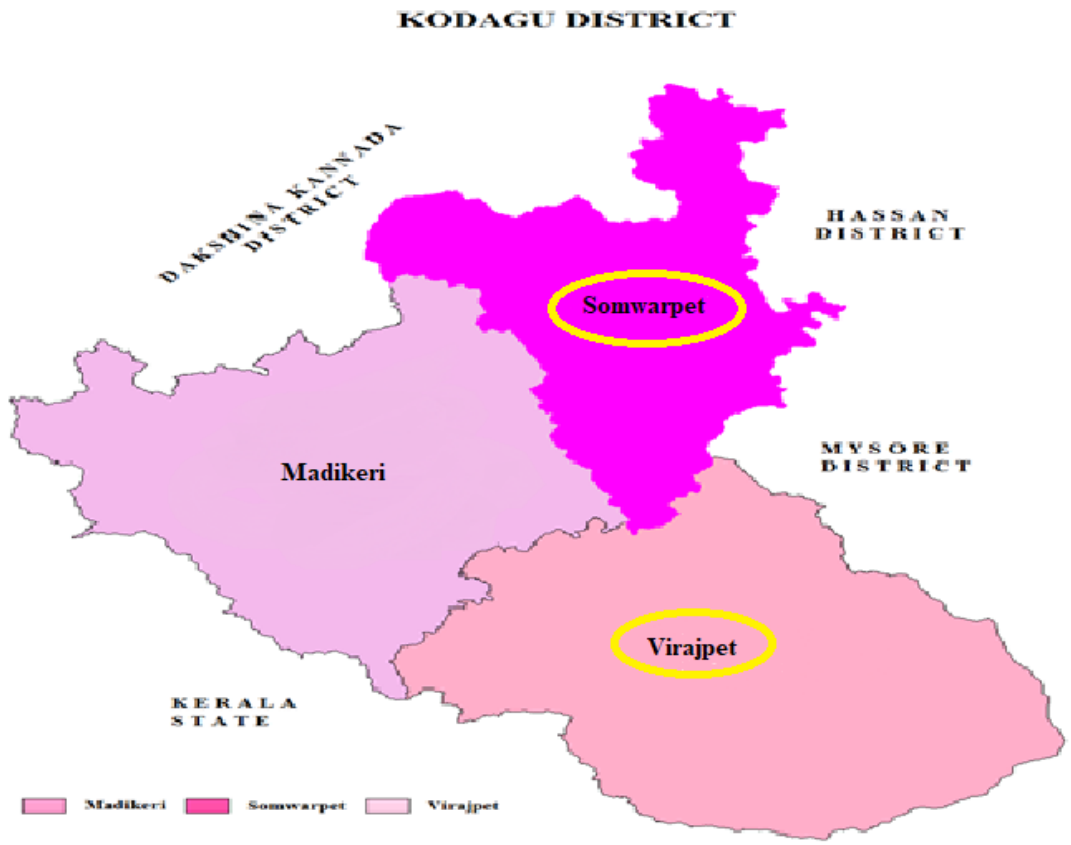

Table 1.3: Population of Kodagu District

Sl. No	Taluks	Population					
		2001			2011		
		Male	Female	Total	Male	Female	Total
1	Madikeri	70,987	71,025	1,42,012	72,966	73,617	1,46,583
2	Somwarpet	1,02,739	1,03,182	2,05,921	101,888	1,04,617	2,06,505
3	Virajpet	1,01,105	99,523	2,00,628	99,754	1,01,677	2,01,431
Total		**2,74,831**	**2,73,730**	**548561**	**2,74,608**	**2,79,911**	**5,54,519**

Source: - Census of India 2001 and 2011

Table 1.4: Population of Scheduled Tribes in Kodagu District

Sl. No	Taluks	Total Population	No of House holds	ST Population			Percentage of ST Population		
				Male	Female	Total	Male	Female	Total
1	Madikeri	1,46,583	1978	3991	4033	8024	5.46	5.47	5.47
2	Somwarpet	2,06,505	2610	5171	5366	10537	5.07	5.26	5.10
3	Virajpet	2,01.431	10506	19348	20145	39493	19.39	20.1	19.60
	Total	**5,54,519**	**15,094**	**28,510**	**29,544**	**58,054**	**10.38**	**10.55**	**10.47**

Source: - Census of India 2011

Kodagu is inhabited by the Kodavas and their subsects, Gowda's, Brahmins, Muslims, Christians and Jains. In addition to these people there are Scheduled castes and Scheduled Tribes such as Kudiya, Kurumba, Meda, Martha and Yerava. Numerically the STs constitute a significant minority in Karnataka. The tribal population is unevenly distributed all over the states and is made up of several tribal communities. District-wise consideration discloses that there are a few pockets of higher concentration and Kodagu is one such district where the STs Population is 10.47 percent. The proportion is higher compared to the State which is 6.95 percent. According to the 2011 census, the district's total population is 5,54,519 whereas the total tribal population in the district is 58,054, with 15,094 households which amount to 10.47 percent of the total population. Majority of these tribes that is 19.60 percent are concentrated in Virajpet taluk. Kodagu is the home to forest-dependent tribes such as Jenukuruba,, Kadukuruba, Kuruba(in Kodagu District), Yerava, Maratinayaka, Meda, Kudiya, Soliga and Nayaka are settled in this district. The Jenu Kurubas are hunter-and-gatherer tribes, who are also expert honey gatherers. They are primitive tribes who work as daily labourers for landlords and plantations in the region. The Kadu Kurubas in the Kodagu district are original inhabitants of Nagarahole and Karnataka. The Betta Kuruba, also food gatherer tribes and they are specialised in crafting bamboo utensils. Soligas too are food

gatherers, diversified into marginal agriculture and herding goats. The Yerava tribes are found in Kerala and Kodagu district in Karnataka. Their main occupation is agriculture and fishing. Tribes such as Yeravas, Kurubas, Airies and Kudiyas, are believed to be the original settlers of the area (Iyer 1964).

Table 1.5: Tribal Population of Kodagu District

Particulars	**Taluks of Kodagu District**			**Total**
	Madikeri	**Somwarpet**	**Virajpet**	
Population	9,177	10,011	38,896	58,084
Hadis and Colonies	23	57	87	167
Families	733	1,260	3,046	5,039
Name of tribes	Kudiya, Maratha, Meda, Nayaka	Yerava, Maratha, Meda, Soliga, Nayaka, Maratinayaka, Jenukuruba, Kadukuruba, Kuruba(in Kodagu District)	Yerava, Soliga, Kuruba,(in Kodagu District) Jenukuruba, Bettakuruba, Kadukuruba, Kudiya	

Source: ITDP, Madikeri

In Kodagu District, there are 167 tribal haadis and colonies in which 5,039 tribal families are residing. The district has a considerably large number of tribes who are working in coffee plantations and needs government hospitals the most. The poor tribals who cannot afford to go to private hospitals are dependent on Primary Health Centres(PCHs), sub-centres and Community Health Centres(CHCs). In Kodagu district, health care is provided by District Health and Family Welfare Department through 29 Primary Health Centres, 7 Community Health Centres, 2 Mobile Tribal Health Units, 24/7 Maternal services in 9PHCs, 196 Subcentres and 11 Ayush clinics under the control of District Health Officer. Besides this, there is one District Hospital in Madikeri and two Taluk Hospitals situated in

Somwarpet and Virajpet taluk under the direct control of the Medical Directorate. In Kodagu district, the PHCs and sub-centres have a shortage of doctors and Auxilary Nurse Midwives (ANMs), smothering most hospitals.

As the tribes in Kodagu are clubbed together under the category of Scheduled Tribes, there is a lack of segregated tribal-wise data and relevant information on a particular tribe is not available. The scheduled tribe population is the highest in the district and it is a challenge for the district health administration to provide good health care for the tribes, as they live in the hilly and interior areas inside the forests. The STs of Kodagu District are at the bottom of the social ladder when health and sanitation indicators are considered. Among the STs, the maternal mortality was 42 percent and infant mortality was 30 percent. The majority of child deaths among the STs occurred at home. This was due to a lack of transport facilities, specialist health personnel, poor sanitation in tribal colonies and hamlets, superstitious beliefs, lack of nutrition and addiction to alcohol (Kodagu District Human Development Report-2014).

However, this monograph is focused on Yerava Tribal Women in Kodagu District. The forests have provided shelter to several wild animals as well as to groups of people who prefer to dwell in the forests or were compelled by force of circumstances to retreat to the forests and lead a secluded life away from the mainstream of society. Yeravas are the most numerous among the tribals with such background (Das 1981). Most of the tribal population is either living in the forest-encroached government lands or in resettled colonies provided by the Government which is very interior in rural areas. The major tribal community found here is that of the yeravas. The yeravas are the localised group who are confined to a narrow belt in the southwestern sector of the state. According to the 2011 census, the yerava population of the district was 26,533 persons, among them 12,967 are male and 13,566 are female. The major tribal communities are the Yeravas, constituting 4.8 percent of the total women

population. Very few Yeravas are found in Somwarpet taluk. Thus, the Yeravas are virtually found concentrated in Virajpet taluk which has an area of 1620 square kilometres. Most of them are agricultural labourers. A few educated persons among the yeravas hold white-collar jobs. The yeravas are distinguished as Panjari and Pani yeravas. Available literature and sources indicate that Yeravas came outside of Coorg. Yerava is the name given by Kodavas when these landless and nomadic people migrated to Coorg as they were dependent on Kodavas. In the Kodava language, the word era means 'beg. era-v-a 'the beggar. So, the Kodavas might have called this tribe *erava *' the beggars' a cover term. The present form the *'Yerava* is an Anglicised version of the name 'erava'. The earliest and brief ethnographic descriptions of yeravas are found in several published works such as Memoirs of the Codugu. Survey Vol II by Connor (1870), Ethnographic Compendium on the Castes and Tribes found in the province of Coorg by Ritcher (1887), "Coorgs and Yeravas" by Holland (1901). A study of Coorg in the Imperial Gazetteer of India by Rice BL (Vol. XI, Mysore and Coorg, 1908, pp-295 & 300), The Coorg Tribes and Castes by L.A.Krishna Iyer(1948), Archeology of Coorg by Subbayya(1978) and Census of India -Yeravas of Kodagu by Das B.K (1981).

Yeravas were distributed on the border of three Southern states namely, Karnataka, Kerala and Tamil Nadu. They are non-vegetarians. The main staple foods consumed by them are Rice, Ragi and Jowar. They eat various pulses, vegetables, fruits, milk and milk products. They collect and eat roots and tubes that are available in the forest (Chandra 2003). Men and women regularly consume alcohol. Smoking beedi, chewing betel leaves and areca nut with tobacco and using snuff are common habits among them. Endogamy is the rule of marriage among them. Boys and girls are married at the age of 16 to 21 years and 12 to 14 years. Land and forest are the main economic resources of the yerava. Usually, parents and their married children are found living near each other. Very few of them own land and cultivate it. Most of them are agricultural labourers or annual contract labourers. The yerava women earn and

contribute towards the family income by working as agricultural labour. They collect fuel and bring water, and do household chores; they play a significant role in social rituals and religious activities.

At present Yeravas are rarely found in the labour lines or tenement houses that one comes across in large coffee estates. They are living in tribal colonies set up by the government and some on forest-encroached government lands. On the other hand, the dwellings in the tribal colonies and also those on the forest or paisari land are built close to each other. Most of the colonies consist of one or two streets, with drainage and some haadis/colonies have electricity and some are interior in rural areas.

Statement of the Problem

The present study was carried out to analyse the health status of the women of Yerava community in Kodagu district. Hence the study is titled "Health Status of Tribal Women: A Sociological Study on Yerava Tribe in Kodagu District".

Objectives of the Study

1. To study the demographic profile of Yerava women
2. To examine the socio-economic condition of the Yerava women.
3. To analyse the health-related issues and factors responsible for the health status of Yerava women.
4. To examine the folk medicine and home remedies in use among the Yeravas.
5. To assess the accessibility and availability of health care services.

Significance of the Study

Health is an important factor for human development. Tribals form a very important part of the study considering that women's health is an important indicator of the well-being of the entire family which in turn indicates the health of the community. Various scholars have studied the health status and health issues of tribal women in different parts of India, the type of diseases that the indigenous groups suffer and the health services available for tribal women in different parts of India. There are some ethnographic studies on Yerava tribes. However, systematic social research and documentation regarding the health status of Yerava women are needed who are the microscopic minority community in Kodagu. Hence this study aims at filling this gap in social research.

Limitations of the Study

1. This study is focused on the Tribal Women in Kodagu District and therefore it may not be directly applicable to other tribes.
2. This study is exclusively on the health status of Yerava tribal women of the Kodagu district.

Methodology

This study is based on primary and secondary data. The research design used for the proposed study is Descriptive Research Design. The area selected for the study is Kodagu District. A field survey was done in the villages of Virajpet and Somwarpet taluks, a total of 390 respondents were selected as samples using the Yamane formula n=N/1+Ne2, and the required sample size was 388. The respondents in the age groups of 18-49 years and above were selected for the study. Fifteen hamlets/colonies were selected and selections of the hamlets/colonies were chosen using a simple random method. The samples for the study were

selected exclusively from the yerava hamlets/colonies and in remote places to get a wider perspective of health status. Primary Data was collected from the respondents through an interview schedule. The help of the Asha workers of the particular colonies was utilised to have a better rapport.

The nutritional status was assessed by Anthropometric Measurements like body weight, height and Body Mass Index. The Body Mass Index was calculated by the height and body weight measurements.

Body Mass Index (BMI) = Weight in Kilogram/ Height in Meter2

The following cuts off points were used: CED BMI< 18.5kg/m2-Underweight, Normal: BMI= 18.5-24.9 kg/m2, Overweight: BMI>25kg/m2. The height was measured with the help of measuring tape to the nearest 0.1cm and the weight was measured with the help of a weighing machine and was measured to the nearest 0.1 kilograms.

Secondary Data was collected from the available literature like library books, published journals, research abstracts, government reports, encyclopedias and internet sources related to the study of health issues and health care of tribes. Relevant literature on the health status of tribal women was reviewed at the University of Mysore, Mangalore and Karnataka State Tribal Research Centre, Mysore and District library in Madikeri.

The primary data collected was edited coded and classified. The analysis was done through SPSS and Microsoft Excel 10. The simple statistical measures as frequency and percentage were used in the study.

Presentation of Thesis

The thesis has been organised into five independent chapters.

The first chapter is an introduction which covers the background, tribal health, factors affecting health, the health care system in India and Government schemes for health care.

This chapter gives the profile of the study area, statement of the problem, objectives of the study, significance and limitations of the study, methodology of the study and chapter scheme.

The second chapter is the literature review related to the study. The review of literature extensively focuses on health, maternal mortality, nutritional status, anaemia, mother and child care and traditional medicine which have been reviewed from national and international scholarly works, books, journals and thesis.

The third chapter presents the socio-economic indicators such as age, marital status, education, income, occupational status, no of children, land holdings, source of drinking water, sanitary facilities and health status examines the general sickness, communicable diseases, type of treatment, medical expenditure, the decision in obtaining health care, work performance, mother and child health, mortality, nutritious food during pregnancy, prenatal and antenatal care, family planning and the factors responsible for health status.

The fourth chapter examines health care services such as availability of primary health centres, distance to health care centres, mode of transport, availability of doctors, free medicines, response in case of emergency, health camps, health insurance, awareness of government health schemes, folk medicines and home remedies.

The fifth chapter will be the concluding chapter which includes listing the major findings and recommendations for future studies based on the study findings.

Review of literature

There are not many studies done so far on Yerava Community especially related to the health status of women. However quite a few studies have covered the health issues of tribal women on other parts of India. Therefore the literature that is reviewed focuses on the seven areas.

Studies related to Health status and Factors for Health Problems

Health status of a community depends upon access to adequate food, nutrition, portages worth and good sanitation facilities. Illiteracy was the cause for lack of health and nutritional consciousness among tribal women, access to health and educational services also play a major role in poverty alleviation. In remote rural areas the tribals suffered on account of factors like inadequate number of primary health centre (PHCs), negligence and insensitive approach of medico-personnel. Under these circumstances the tribals are left with no option but to turn to traditional healers in the villages. Education and health are most important element in the development of any community (**Anjali 2013**).

The primitive tribes of Orissa still depend on hunting and food gathering as a primary source of livelihood. Widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary conditions, poor maternal and child health services, ineffective coverage of national health and nutritional services, etc.,(**Chhotray 2003**) have found to be the contributing factor for the dismal health condition prevailing among the primitive tribal communities of the country. Non-communicable diseases like diabetes and hypertension is not prevalent indicating that the primitive communities are still far away from modern civilization and developments. In spite of tremendous advancement in the field of preventive and curative medicine, access to health care delivery services for primitive tribal people is still poor.

Studies on Infant and Maternal Mortality

Infant mortality rate is an important index of the level of socio-economic development and quality of life. It is a sensitive indicator of the availability, utilization and effectiveness of the healthcare particularly prenatal care. It is persistent undernourishment of women and girl child in particular, that is emerging as critical factor responsible for infant

mortality. Poor maternal health results in low birth weight and premature babies, infant and childhood diarrheal diseases, acute respiratory infections, and malnutrition contribute to high infant mortality rates (**Balgir 2007).**

The infant mortality rates were very high in four primitive tribes namely Bondo, Didayi, Juang and Kutia Kondh of Orissa. There was high maternal mortality rate, high crude death rate. The unhygienic and primitive parturition practices were mainly responsible for high maternal mortality (**Basu et al. 1990, Basu 2000**). In India nearly 12% of all maternal deaths are attributable to abortion related complications and 23% maternal deaths were due to bleeding during pregnancy (**Balgir 2007).**Similar views were reported (**Basu and Kshatriya 1992)** that the Kharia tribes of Orissa had high rate of fertility, crude birth rate, crude death rate and infant mortality compared the national population of India.

Studies on Nutritional status of women

The physical well-being and maintenance of normal health of an individual is closely related to the status of nutrition. Proper nutrition keeps man healthy and fit and inadequate or improper nutrition reduces fitness and causes susceptibility to disease. Nutritional status refers to health of an individual as it is determined by the intake and their utilization **(Bera 2004).**

Nutritional status of individuals and general conditions indicates the socio-economic conditions prevalent in the society. Malnutrition is a common health issue in tribal areas and has greatly affected the general physique of the population. It lowers the ability to resist infection, leads to chronic illness and in post weaning period leads to permanent brain impairment Good nutrition is required throughout life and is particularly vital for women to continue to remain in good health and to do everyday household work. Maternal and child care was largely neglected among the tribal women of Baster district. Proper preventive

health practices like immunization and vaccination of expectant mothers as well as new born was largely absent. The consumption of iron, calcium and vitamins during pregnancy was poor. More than 90 per cent of the deliveries were conducted at home attended by the elderly ladies of the household. In addition a lot of women suffered ill health due to pregnancy and childbirth in the absence of well-defined concept of health consciousness. As far as child care is concerned both rural and tribal illiterate mothers' breast fed their babies. But most of them adopted harmful practices of discarding of colostrums, delaying the initiation and immunization of infants and introduction of supplementary foods (**Kshatriya 2014**).

Studies on Nutritional status of pregnant women

The Dietary patterns of people also affect the nutrition security of a community. In many cultures, the dietary patterns followed do not meet the nutritional needs (quality as well as quantity, minor and major nutrients) of the individuals and affect the health and nutritional status of the community. Low dietary intake by already malnourished women has adverse effects on the health of both mother and child (**Balgir 2008**)

Maternal Malnutrition was common among tribal women especially those who had many pregnancies too closely spaced. Tribal diets are generally grossly deficient in calcium, vitamin A, vitamin C, riboflavin and animal protein (**Basu 2000**). Among the Kutia Khondhs the delivery was conducted by the mother. In complicated cases it will lead to maternal and child mortality. Some of the crude practices existed among the tribal groups like Gonds, Kharias, Santhals, Kutia Khonds of Orissa. Expectant mothers were not inoculated against tetanus. From the inception of pregnancy to its termination, no specific nutritious diet is consumed by women. The consumption of iron, calcium and vitamins during pregnancy was poor. The habit of taking alcohol during pregnancy was found to be usual in tribal women and almost all of them continue to do their regular activities including hard labour during

advanced pregnancy. More than 90% of deliveries were conducted at home attended by elderly ladies of the household. Among the Khonds women put in 14 working hours per day as compared to 9hrs put in by men. Women in advanced stages of pregnancy worked in agricultural fields or walk greater distances to collect fuel and minor forest produce.

Studies related to Anaemia

The tribal women in Orissa was married at a very young age, majority of them were illiterates, underweight and anaemic. They were less exposed to the outer world which deters them in their development and utilization of health care services compared to non-tribals. Maternal health care was an important aspect of health seeking behaviour, which is largely neglected among them. Uses of contraceptives are very less and unintended pregnancies are quite high among these tribal women. The low health modernity status is due to their own beliefs, illiteracy, poverty and lack of access to scientific information.(**Agarwal 2013**).

Nutritional anaemia was a major problem for women in India and more so in rural and tribal belt. This was particularly serious in view of the fact that both rural and tribal women had heavy workload and anaemia had profound effect on psychological and physical health. Anaemia lowers resistance to fatigue, affects working capacity under conditions of stress and increases susceptibility to other disease (**Basu 2000).**

Continuous earnings throughout the year and debt free condition of the family have been found to be having significant influence on BMI. The prevalence of anaemia was 60.9percent **(Nayak et al. 2016).** It was higher than the national average in reproductive age group women which according to NFHS-3 was 55per cent. NFHS-4 reports that the 59.8 percent ST women in India are anaemic.

Studies related to Mother and Child Care

An important aspect of health seeking behaviour is the maternal and child care which is largely neglected among the tribal groups. Among the Kutia Khonds the main cause for maternal mortality was unhygienic and primitive practices for parturition (**Basu et al. 1990).** It was observed that delivery was conducted by the mother herself in a half squatting position holding a rope tied from the roof of the hut. In complicated labour it may lead to maternal and child mortality. Similar crude practices were found among other tribal groups like Kharies, Gonds and Santhals, Most of these tribal women adopted harmful practices of discarding of colostrum, delaying the initiation of breast feeding and introduction of supplementary feeds. Vaccination and immunization of infants and children were inadequate among these tribal groups. Personal hygiene was very poor, magico-religious beliefs and taboos tend to aggravate the problems. These tribes believe that diseases are caused by hostile spirits, ghosts or breach of some taboos; they seek remedies through magico-religious practices to propitiate the supernatural powers which were given first preference. Next preference was given to herbal medicines or indigenous medicines which were obtained through local people. It was observed that these four tribes (Gond, Muria, Bhattra and Halba) perpetuate the use of Tulsi leaves, turmeric powder in case of fever and injuries, they used indigenous concoctions to avoid pregnancies, treatment of infertility and for some common ailments.

Among the tribal women of Kerala, 11.4% delivered at home and all the home deliveries were attended by untrained persons from the locality. Education of woman was an important factor affecting utilization of maternity care services by tribal women. Level of education of the tribal women who did not utilize full services was significantly lower than who utilized maternal health care services. 5.7% of tribal women were of the opinion that

ANC and delivering at the hospital were unnecessary, believed that medicines and injections are harmful and will cause other health problems**.(Jose et al. 2014)** The determinants that helped tribal women to utilize maternal care services from government hospitals was better information regarding early maternal care, free treatment, affordable, accessible and good quality of services, availability of health professionals and motivation by health workers. Lack of transport facilities coupled with lack of awareness and financial constraints were the factors for under-utilization of maternal care services.

Studies related to Traditional Medicine

The Botto people of Ladakh used 53 different species of plants for the treatment of cold, cough, and fever. Various parts of the plants are being used in the treatment of the illness (**Ballabh et al. 2007**). Another study by them showed that 68 medicinal plants were used for the treatment of diseases such as kidney and urinary disorders among the tribes of Ladakh. The medicines were used either in tablet and powder form (**Ballabh et al. 2008**).

An Ethno botanical study was done among the tribes of Mysore and Coorg Districts. The 14 tribes used different plants and barks of trees to cure cough, cold, rickets, fever, vomiting, toothache, headache, giddiness and Dysentry (**Kshirsagar 2001**).

The Jenukuruba and Kadukuruba tribal women (use ethno-medicines such as herbs, leaves and roots) use indigenous medicines as contraceptives (**Mutharayyappa 1994**). Among the jenukuruba women 40.6 per cent used indigenous medicines for preventing pregnancies or postponing births. Only 13.2 per cent of the women use modern contraceptives. On the other hand, among the kadukurubas more women 24.8 percent used modern methods of contraceptives. Only 6.8 per cent used indigenous medicines for preventing or postponing pregnancies.

Major Findings

Based on discussions and analysis in the preceding chapters, the major findings of this study:

Socio-Economic Status of Yerava Women

The study was conducted on Yerava Tribal Women in Kodagu District, Karnataka State. The respondents' socio-economic status shows that the majority are in the age group of 18 - 47 and above, (84.4%) are married, with few cases of separation and widows. In the case of religion majority of them are Hindus.

Regarding educational and economic status, including their occupations and landholdings, 53.9 percent are illiterates only 0.8 percent are graduates. The average education level is primary and secondary as most of them drop out from school when they reach this level, the reason being due to lack of motivation, encouragement and parental education. With respect to their occupations, a large majority (91.8%) work as daily wage labourers and 75.9 percent have an income of Rs 10.000 – 15000 per month. On the other hand, 61 percent of the respondents are landless, whereas very few own 2 to 3 acres of land.

The study shows that 97.7 percent of the respondents have nuclear families. 46.5 percent preferred to have a small family. Prevailing economic conditions are the reasons for the small size of families and this changes from family to family depending on their ability to sustain themselves. The majority of them lived in houses made of brick walls with tiled roofs and very few were homeless. The houses were built by the government under housing schemes. Most of them are members of the Self-Help Group, which helped them gain confidence in dealing with money matters and social interaction. 35.4 percent save their income. Most houses are electrified and 62.1 percent use firewood for cooking. Most of the respondents use water from taps, tube wells and tanks, and a majority of them do not treat

water before drinking. One of the significant factors which influence health is the sanitary facility. Majority of the respondents (81.3%) had their sanitary facility and very few (15.6%) go for open defecation. With regard to hygiene and sanitation, these women keep their houses and surroundings clean and tidy. Thus, a majority of the women are not enjoying socially and economically better status.

Health Status

The Yerava women have a moderate health status. Very few (9.8%) have poor health status, due to their addiction to liquor and tobacco and their reluctance to seek medical help. Majority of women in the study stated that they did not have any major health complications, but had general sickness such as fever, cold, headache, backache, allergy, stomach ache, gastritis, diabetics and anaemic. The communicable disease in the study was 0.8 per cent. Very few cases of tuberculosis are found in a very small percentage of women thanks to active government T.B eradication programmes and well supported by the health department and ASHA workers. However, 89.7 percent visited government hospitals for treatment and 23.1 percent consume traditional medicines. For medical expenditures, 57.9 percent borrowed money from the plantation owners and 42.1 percent used their savings, majority (89%) of the women take decision alone in obtaining health care. Regarding work performance, 69.4 percent who work for 10 hours have moderate status.

Mother and Child Health

Women's maternal health is the essential factor that determines their overall health. 64.1 percent of women attained puberty at 12 – 13 years. The study reports that 18.5 percent of respondents got married at 14-16 years. They opined that they were married soon after puberty at a very young age; 42.1 percent were married at 16-18. Pregnancy and childbearing are natural occurrences, and women regard childbirth as a natural process. 51.2 percent of

women conceived at a very young age of 16-18 years, and more than half of the respondents (51.9%) conceived twice. Very few respondents had problems during pregnancy like swelling of the legs, body or face, anaemia and complications such as miscarriages and stillbirths. The infant mortality rate was low (5.9%). The respondents opined that infant mortality was due to low birth weight (5.4%) and high fever and convulsions (0.5%). Low birth weight of the infants is primarily due to malnutrition and anaemic conditions of the childbearing women. The incidence of infant mortality is very low among these Yerava women, as grass-roots health workers like ANMs and ASHA workers provide prenatal and postnatal care to every pregnant mother. They are given free medication and nutritious midday meals. Other factors include traditional eating habits and mental fortitude. Nutritious food during pregnancy has important implications for the mother and childbirth. No special food was consumed during pregnancy. All the respondents in the study area during their pregnancy consumed vegetables as it was grown in their kitchen garden with organic manure, but very few consumed fruits (1.3%) and milk (14.1%).

Antenatal care is vital for the health of both the mother and the unborn child. 25.4 per cent visited the health care centre during the first trimester. Only 12.8 percent had four ANC visits and 39.4 percent did not receive any antenatal care. Not all the respondents could use the facilities provided by the government. Lack of transport from home to hospital, lack of awareness about medical services and financial status are some of the reasons for not making use of these services. Home delivery was still common among the respondents and the umbilical cord was cut by a clean blade, a usual practice among these tribal women. 48.9 percent had institutional delivery and 51.9 percent of respondents were assisted by health professionals during delivery. ANM and ASHA workers played a vital role in motivating the respondents for institutional delivery. Most of the respondents stated financial difficulties, no

proper roads and transportation as the reason for not utilising health care facilities. The study reports that among the respondents, 30.4 percent had post-natal check-ups during the first two days after birth, and 32.3 percent had check-ups after two months of delivery. Maternal mortality was very low (0.5%). 60 percent breastfed their children within one hour after birth and 68.1 per cent breastfed for more than one year. Most of the respondents have immunised their children; this was mainly due to ASHA workers' efforts. The study shows that 31.8 percent have knowledge and are aware of the transmission of HIV/AIDS. Majority of them do not know, so they need to be educated.

Consumption of a wide variety of nutritious food and a well-balanced diet with adequate protein, fat, carbohydrate, vitamins and minerals are required for women's health. 86.2 percent consumed green leafy vegetables daily, whereas 75.7 percent never consumed milk/curd, but eggs, fish, chicken and meat were consumed weekly. Majority of the respondents utilised the special nutrition programme given by the government. The respondents opined that the nutritious supplements were not of good quality. The nutritional status of yerava women is linked to their Body Mass Index (BMI). Malnutrition among the respondents has been assessed using the body mass index. Study shows that 31.3 percent of women are malnourished with a BMI of less than 18.5, indicating nutritional deficiency, 62.8 percent of women have a BMI in a normal range between 18.5- 24.9. Majority (78.1%) of the respondents are aware of family planning, the most preferred method of family planning was tubectomy (70.5%), and 56.8 percent adopted this method after their second child. The source of information about family planning was from ASHA workers and ANMs.

Factors responsible for health conditions

Many factors affect the health of women, whether they are healthy or not are determined by their circumstances and environment. Women's health is influenced by the

social and economic conditions in which they live, their income, their educational level, and the type of work and habits they follow. 80.5 percent of respondents took 8 hours of rest. Majority (75.3%) never worked when they were sick, whereas 5.3 percent always worked when they were sick, as they had to look after and feed their family. 71.3 percent stated that climate did not affect their health as they naturally resist extremes of weather. 60.3 percent have never consumed alcohol, but 14.9 percent aged 48 and above consume alcohol on a regular basis. 60.8 percent chew tobacco daily. Tobacco is also an intoxicant that most Yerava women use and are in the habit of chewing along with betel nuts and betel leaves. 75 percent of respondents sometimes believed in supernatural powers when they were sick. This shows that the community's culture, customs, and beliefs influence their health. All the respondents stated that early marriage, followed by illiteracy and ignorance, were the causes for health problems.

Health Care Services

Health care services are essential to provide good quality services to tribal women. Study shows that all respondents opined that they have Primary Health Centre in their village or a nearby village. The study shows that a large majority of the respondents (85.8%) are availing services and facilities provided by the Primary Health Centres. This shows an encouraging and positive attitude towards the use of modern medicines. 49.8 percent of respondents have to travel 5-10 kilometres by auto to seek treatment. Majority of the respondents stated that the working hours were convenient, but they had to wait long hours to get treatment. 87.5 percent stated that there were doctors in the PHCs who treated them well, but 35.3 percent are of the opinion that they did not treat them properly. 59.7 percent reported that they sometimes got free medicines from the health care centres they visited. During emergencies, 20 percent of the respondents stated that there was a delay in providing proper

treatment. Majority (89.7%) of the women were unaware of free health check-ups conducted in their villages. The majority of the respondents opined that the ASHA workers visits regularly and they are very helpful, but some have complained that the ASHA workers give more attention to pregnant women and never bother about the health of other women. 44.1 percent stated that the ANMs visited their houses and distributed medicines and 55.9 percent of women said that ANMs never visited their houses to distribute medicines. Study shows only 5.6 percent respondents have health insurance coverage under Ayushman Bharath-Pradhan Manthri Jan Arogya Yojana, Yashashwini health card and Arogya Karnataka, which aims at providing free access to health. The coverage of Health insurance in the study area is far from satisfactory. The study reports that the respondents are unaware of government sponsored schemes for uplifting women, the reason being lack of education, lack of information about these schemes, the disinterest showed by these women in understanding these schemes and the inability to produce needed documents to avail these schemes.

Traditional Medicine

Since time immemorial, Yerava women have been using traditional medicines. But in recent years, only 3.1 percent of respondents have reported practising traditional medicine; they use different plants, leaves, roots, and bark of trees to prepare medicines. These respondents are in the age group of 50 and above. The respondents who used traditional medicines (7.7%) believe they are very effective. Most respondents commonly use home remedies for fever, cold, and other minor ailments. If the sickness is not cured by the traditional method, they resort to the modern methods of treatment.

Traditional health practices

Traditional Medicines are used to cure different ailments by the respondents. They used different parts of plants, leaves, seeds, berries, barks, flowers and roots to prepare these medicines.

Traditional medicine used to cure different health ailments.

Name of the ailment	Name of the plant (Botanical name)	Local Name	Part of the plant	Ethno-medical uses/Preparation
Cough	Ocimum tenuiflorum	Tulsi	Leaves	Leaves with honey and ginger thrice a day.
	Ruta graveolens Artemisia argyi	Nagadali Galimadu	Leaves	The leaves of these plants are ground with garlic and turmeric and the extracted liquid is consumed. Dosage: 1 tbsp. for children and 3 to 4 tbsps. for adults
	Leucas aspera	Thumbe	Leaves	Leaves are grounded with garlic and honey is consumed thrice a day
	Coleus amboinicus	Doddapatre	Leaves	The leaf is heated in a pan and the juice is extracted. A tablespoon of juice mixed with honey is consumed orally twice a day for 5 days on empty stomach
Cough and Cold	Piper nigrum Allium cepa Allium sativum	Pepper Corns Eeruli Belluli	corns, pods, seeds, pulp	Boil crushed pepper, onion, garlic, cumin seeds, coriander leaves and tamarind in water. Strain the mixture and consume.
Cough and Fever	Allium sativum Curcuma longa	Garlic Turmeric	Pods Rhizome	Garlic and turmeric are grounded in coconut oil and applied on the forehead, few drops are applied to the nose

Fever	Guilandina bonduc	Fever Nut	Leaves & Seeds	The leaves and seeds are boiled and the concoction is consumed for high fever thrice daily.
	Ruta graveolens and Artemisia argyi	Narvisa/ Nagadali Galimadu	Leaves	The leaves of these plants are ground with garlic and turmeric and the extracted liquid is consumed.
Headache cold, cough and anaemia	Solanum anguivi	Kaisunde	Berries	Hot soup is made with berries to prevent asthma, cold and cough. Berries are consumed in the form of curry to prevent anaemia. The seeds of the ripe fruits are applied on the forehead to cure headaches.
Sore Throat	Leucas Aspera	Thumbe	Leaves	Leaves and Lime stone powder is ground into a paste and applied externally'
Migraine Headache	Leucas aspera	Thumbe	Leaves	Leaves are crushed and the extracted juice is applied to the nostrils
	Vitex negundo	Nokki Soppu	Leaves	Extracted juice from the leaves of vitex negundo is applied to the nostrils twice daily to cure migraine headaches
Dysentry/ Diarrhoea	Mangifera indica	Mavina Mara	Bark	Bark ground with jeera and curd is consumed orally on empty stomach thrice a day
	Terminilia elliptica	Mathi Mara	Bark	Bark and root extract is consumed to control dysentery thrice a day.
	Punica granatwn Psidium guajava	Dalimbe Mara Seebe	Tender Leaves	Tender leaves are ground with cumin seeds and mixed with curd and a pinch of salt and consumed orally
Stomach ache	Butea monosperma	Muthuga	Bark	Roots of Butea monosperma are ground with egg shells and applied on the stomach around the naval of babies.
Stomach Ulcers	Aloevera	Lolisara	Leaf inner gel	Leaf inner gel is consumed for 1 month to cure ulcers in the stomach or intestine

Amoebic Dysentery	Syzgium cumini	Nerale	Bark & Seeds	Decoction of the bark of syzygium cumin and Mangifera indica is consumed orally
				The bark is ground with cumin seeds and the extract is consumed orally for dysentery.
Menstrual Stomach ache and Fever	Artemisia argyi	Galimadu	Leaves	Leaves of Artemisia argyi are grounded with turmeric and garlic and made into small balls and consumed.
Giddiness/ Fatigue Body ache	Pongamia Pinnata	Honge Mara	Bark	Bark extraction is ponded with garlic and smeared on the body to control giddiness. Bark juice is mixed with kerosene in 1:1 proportion is rubbed on the body to cure body aches
	Rhaphidophora Pertusa	Sokku balli	Stem	The stem of the plant is crushed with turmeric and garlic, the juice is extracted, and hot iron is immersed into the mixture and consumed twice daily for 2 days. The mixture is smeared on the body also
Sprain	Thunbergia fragrans White Florido Vine Flower	Indra Pushpa	Flower	Grind the flower with castor oil and apply it externally on the sprain
Fever/Urinary infection	Mimosa Pudica	Lajjallu/ Muttidare Muni	Roots & Leaves	The decoction of the roots is consumed for kidney stones. The paste of the leaves is applied on fresh cuts and wounds to stop bleeding, and the leaves decoction is used for fistula
	Terminilia elliptica	Mathi Mara	Bark	Bark decoction is consumed thrice a day.
Urinary tract stones and Chronic dysentery	Phyllanthus niruri	Nellanelli/ Kirunelli	Whole Plant/ Leaves	The juice of the whole plant is consumed thrice daily for chronic dysentery and indigestion. Fresh leaves are chewed for urinary tract stones.

Chicken Pox Measles	Azadirachta indica Ruta graveolens Artemisia argyi Coleus amboinicus Curcuma longa	Neem/Bevina Soppu Narvisa/ Nagadali Galimadu Doddapatre Turmeric	Leaves Rhizome	Leaves of Azadirachta indica Ruta graveolens, Artemisia argyi, Coleus amboinicus is ground along with Curcuma longa and black cumin seeds are ground together, the extracted juice (2tablespoons) is consumed for 15 days. The grounded mixture is also smeared on the body for 15 days.
White discharge	Centella asiatica	Ondelaga/ Brahmi	Leaves	Grind the leaves of Brahmi and half a teaspoon of jeera with hot water; add buffalo milk to the mixture and consume one tablespoon thrice daily for 3 months
Diabetics	Syzygium cumini	Nerale	Seeds	Seeds are dried; the ground powder is mixed in hot water and consumed once a day for a month.
Jaundice	Butea monosperma	Muthuga	Stem bark	The stem bark is crushed and soaked in a glass of water overnight, filtered, mixed with fresh cow's milk and consumed for a week.
	Phyllanthus niruri	Nellanelli/ Kirunelli	Whole Plant/ Leaves	Leaves are crushed and the extracted juice is taken orally for jaundice.
	Centella asiatica	Ondelaga/ Brahmi	Leaves	Leaves are crushed in buttermilk and consumed on empty stomach early in the morning for 7 days.
Post Natal Care	Azadirachta indica Ruta graveolens Artemisia argyi Plectranthus /Coleus amboinicus Curcuma longa	Neem/Bevina Soppu Narvisa/ Nagadali Galimadu Doddapatre Turmeric	Leaves Rhizome	Leaves of Azadirachta indica, Ruta graveolens, Artemisia argyi, Coleus amboinicus is ground along with Curcuma longa and black cumin seeds are ground together, the juice is extracted hot iron is immersed and 2 tablespoons of juice are consumed early in the morning on empty stomach once daily for 5 to 7 days.

Scabies	Black Tortoise Shell		Shell	Burn tortoise shell powder, grind garlic and mustard add coconut oil and boil the mixture. Apply on the skin thrice daily.
	Aloe vera	Lolisara	Leaves	Leaf pulp crushed in neem oil is applied to the wound.
Scabies and ring worm Skin allergy	Coleus amboinicus	Doddapatre	Leaves	Leaves are crushed and smeared on the body for skin allergy.
Catepillar Sting Allergy	Selaginella bryopteris	Sanjeevani	Leaves	Leaves are crushed and applied externally on the affected area.
Foot Corn	Calotropis gigantean	Yaka	Leaves	Leaves grounded with mustard oil and turmeric is applied on the skin. Latex mixed with mustard oil is applied on the skin.
			Latex	Latex of the stem is oozed on the foot affected by foot corn infection and the leaves are crushed and made into a paste and tied with the leaf of Calotropis until the infection is healed.

Quality of Government Health Facilities

The quality of medical services available in the villages plays a significant role in the availability of health care services. 31.7 percent were satisfied with the quality of health facilities and health infrastructure and 41.5 percent reported that they were dissatisfied with the health facilities. Majority of them stated that they need improvement in the health facilities and services and suggested providing good transport and good hospitals with skilled health professionals.

Suggestions

1. The study reports that most of the Yerava women are educationally, economically backward and unaware of health issues, so education is the key to empowering these Yerava women.
2. To motivate Yerava women health camps should be organised in the village to create awareness about the utilisation of pre-natal and post-natal care, nutrition, health issues, the availability of free medical facilities in PHCs and various government schemes.
3. This study reports that the majority of the respondents seek health services from Primary health centres which are considered cornerstones of rural health care services These PHCs and sub-centres should be upgraded. Efficient skilled health professionals, well-equipped laboratories, free medicines should be provided and skilled ANMs and ASHA should be appointed for each village.
4. Health education and health awareness campaigns should be emphasised to strengthen healthcare services.
5. Adequate transport facilities should be provided to these women to access the health care facilities.
6. This study is focused on the health status of Yerava tribal women of Kodagu District. An in-depth comparative study can be undertaken on other tribal groups in the district.

Conclusion

Women's health is a nation's wealth. It is the quality of life rather than an absence of disease. So health is the most important aspect and the pillar of human personality. Health is a prerequisite for human development. Health is a multi-dimensional aspect which includes the well-being of mind, body and the environment we live, clean air, hygienic drinking water and accessibility to good and cheap medical care are some of the aspects of maintaining good health.

This study shows that the Yerava tribal women in Kodagu District being illiterate with low economic status have moderate health status. Most of them do not suffer from any major communicable diseases. Most Yerava women belonging to different age groups have common general health issues – cold, fever, body pain, backache and headache. Nutrition is the cause of concern as some of the respondents have low BMI. Maternal and infant mortality is low among them. There is a decrease in seeking traditional healing practices and an increase in seeking modern services from government health facilities. The study reports that the women are unaware of the Government sponsored schemes.

Study shows that Yerava women have managed to adopt a change along with the modernisation of society and have not been left behind in aspects of life, health and livelihood.

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